Medicaid Information Bulletin

January 1999

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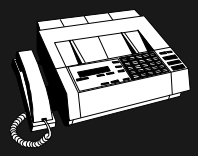

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Medicaid Information: In the Salt Lake City area, call **538-6155.** In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free **1-800-662-9651**. From other states, call **1-801-538-6155**.

99 - 01 Reminder: All Paper Claims Must Be Sent by Mail

Please remember that the Martha Hughes Cannon Building is a secure building. Public access is restricted to the lobby area, cafeteria, vital records, and a designated conference room, all located on the first floor. Access to other areas of the building will require an employee escort. State and Federal privacy laws do not permit staff at the Martha Hughes Cannon Building's information desk, or any other reception desk in the building, to handle Medicaid claims.

All Medicaid paper claims must be sent via the U.S. Postal Service. Please mail claims to:

Bureau of Medicaid Operations
P.O. Box 143106
Salt Lake City, UT 84114-3106

Medicaid will not be responsible for claims left in the building.

If you are interested in learning more about electronic billing, or to find out if you are eligible to bill electronically, please call Medicaid Information at (801) 538-6155, or toll free at 1- 800-662-9651. Press 3, then 5. **G**

99 - 02 Health Common Procedure Coding System - 1999 Revisions

Effective for dates of services on or after **January 1, 1999**, Medicaid begins accepting the 1999 version of the Health Common Procedure Coding System (HCPCS). HCPCS codes include the 1999 Physicians' Current Procedural Terminology (CPT) codes. Continue to obtain prior authorization required for procedures on the 1998 list, even though new codes may be added for the same or similar procedures, or codes may be changed on the 1999 list.

The April 1999 Medicaid Information Bulletin will contain details concerning coding changes for services by physicians, medical suppliers and so forth. Any 1998 HCPCS codes discontinued in 1999 may be used for dates of services prior to April 1, 1999. For services on and after April 1, 1999, providers must use the 1999 HCPCS codes.

If you have a question concerning billing the 1999 HCPCS codes, please contact Medicaid Information. **G**

99 - 03 Name Changes for Medicaid Managed Care Plans

Two managed care plans which contract with the Utah Medicaid Program have changed names.

University Health Network is now **HEALTHY U**

The University Health Network changed its name to Healthy U, effective November 1, 1998. The Medicaid Identification Card for enrolled clients now states **HEALTHY U**.

Pacificare Health Systems is now **ALTIUS**

Pacificare Health Systems was renamed Altius Health Plans, Inc., effective November 1, 1998. The Medicaid Identification Card for enrolled clients now states **ALTIUS**.

There is no change in services covered under either managed care plan. As a reminder, please remember that:

- Clients must receive medical services from providers affiliated with the plan printed on the Medicaid Card.

- Clients must receive pharmacy and dental services from a pharmacist or dentist who is a Medicaid provider. **G**

99 - 04 Unacceptable Billing Practices

The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed. Following are examples of unacceptable billing practices.

A. Duplicate billing or billing for services not provided, overstating or mis-describing services, and similar devices;

B. Submitting claims for services or procedures that are components of a global procedure;

C. Submitting claims under an individual practitioner's provider number for services performed by the practitioner as an employee of or on behalf of a group practice or clinic when the service has been billed under the group or clinic number;

D. Use of more intensive procedure code than the medical record indicates or supports. **G**

99 - 05 Filing Medicare/Medicaid Crossover Claims

Please review the policy below from the Utah Medicaid Provider Manual, Section 1, Chapter 11 - 6, *Medicare/Medicaid Crossover Claims*, and ensure crossover claims for fee-for-service Medicaid clients are submitted correctly.

11 - 6 Medicare/Medicaid Crossover Claims

A Crossover Claim is a single claim for both Medicare and Medicaid-covered services submitted to and processed by the Medicare Intermediary in Utah (Blue Cross/Blue Shield). If a patient has both Medicare and Medicaid coverage, **file the claim with Medicare Crossover**. The claim will be processed automatically by Blue Cross/Blue Shield, and payment will be made to the provider for both Medicare and Medicaid-covered services.

The Medicare payment and Medicaid payment, if any, for coinsurance and deductible, is considered payment in full. The Medicaid Crossover payment appears on the Medicaid Remittance Statement under the section for Crossover claims.

Medicaid Crossover payments are made automatically if the provider accepts assignment for Medicare Part A and Part B claims. Providers do not have to submit a separate crossover claim to be paid for the Medicare coinsurance or deductible amount.

Address for Filing Crossover Claims

Mail crossover claims to:

Medicare/Medicaid Crossovers
Dept. 14
P.O. Box 30269
Salt Lake City, UT 84130-0269

For additional information, refer to Section 1, Chapter 11 - 7, *Filing Crossover Claims*. **G**

99 - 06 Home Health Code Y0115: Criteria Changed

The criteria for home health code Y0115, has been changed to make them consistent with the policy for supportive maintenance. Home health providers will find attached page 30-31 with the new criteria for code Y0115. The remainder of this bulletin explains the changes.

The first two items of the criteria for code Y0115 which appears on page 30 of Section 2 of the Utah Medicaid Provider Manual for Home Health Services are changed as follows:

1. Care needs have stabilized to the point that few significant changes are occurring in the plan of care. Client requires assistance with activities of daily living to prevent bed confinement or nursing home admission.

2. Plan of care needs must be based on physician orders and an approved plan of care with review and recertification every 60 days. Care plan must document specific need for 91-120 minutes of care.

The remaining items, 3 and 4, are correct as written.

With the change in items 1 and 2, the criteria for code Y0115 are now consistent with the policy in Section 2, page 15, *Supportive Maintenance*. For your convenience, this policy is repeated below.

"This level of service is available to the patient with nursing care needs that have stabilized to the point that there are few significant changes occurring in the plan of care. The patient demonstrates limitations or significant disability which requires assistance with activities of daily living and could be totally bed bound or subject to nursing facility admission without the assistance. Care and service needs are based on physician orders and an approved plan of care, with review and recertification every 60 days." **G**

99 - 07 Hospital Administrators: New DRGs

Nine DRGs have been added to the Utah Medicaid Inpatient Hospital reimbursement table. They are effective with dates of discharge on and after October 1, 1998. The new codes are described below.

DRG	Description	Medicaid Weight	ALOS	Outlier Threshold
109	Coronary Bypass w/o cardiac catheter	3.7603	7.0	10
504	Extensive 3rd degree burn w skin Graft	13.0355	23.7	36
505	Extensive 3rd degree burn w/o Skin Graft	1.6508	2.3	4
506	Full thick Burn w Sk graft or inhal inj w cc or significant trauma	3.9228	12.2	18
507	Full thick Burn w Sk graft or inhal inj w/o cc or significant trauma	1.5772	6.6	10
508	Full thick Burn w/o Sk graft or inhal inj w cc or significant trauma	1.3093	5.3	8
509	Full thick Burn w/o Sk graft or inhal inj w/o cc or significant trauma	0.7225	3.4	6
510	Non-Extensive burns w cc or significant trauma	1.0740	4.9	8
511	Non-Extensive burns w/o cc or significant trauma	0.5580	3.5	7

The burn-related DRG's described above replace the following DRG's: 456 through 460 and 472. Should you have any questions, please contact Leonard Rustad at (801) 538-6441, or call Medicaid Information toll-free and ask to be transferred to Leonard Rustad. **G**

99 - 08 Non-Covered 1999 ICD-9 Surgical Codes

Medicaid has reviewed the new ICD-9-CM codes for 1999 and determined the codes listed in this bulletin will not be covered by Medicaid. Other new codes not listed in this bulletin are covered by Medicaid, and prior authorization is not required.

Non-Covered ICD-9 Codes

The following ICD-9 codes are **NOT** covered by Medicaid:

36.31 Open chest transmyocardial revascularization

36.32 Other transmyocardial revascularization

36.39 Other heart revascularization

37.67 Implantation of cardiomyostimulation system

92.30 Stereotactic radiosurgery, not otherwise specified

92.31 Single source photon radiosurgery

92.32 Multi-source photon radiosurgery

92.33 Particulate radiosurgery

92.39 Stereotactic radiosurgery, not elsewhere classified

G

99 - 09 Mandatory Newborn Hearing Screening

Effective July 1, 1998, Senate Bill 40 requires hospitals with at least 100 births per year to screen all newborns for hearing loss prior to discharge. By July 1, 1999, all hospitals and birthing centers must comply with the law.

The responsibility for payment and reimbursement depends on three factors:

1. Whether the mother is covered by a managed care plan; or
2. Whether the mother is a fee-for-service Medicaid client in a hospital in Salt Lake, Utah, Davis or Weber Counties; or
3. Whether the mother is a fee-for-service Medicaid client in a rural hospital in a county other than Salt Lake, Utah, Davis or Weber Counties.

HMO clients

When a mother and newborn infant are enrolled in a managed care plan or HMO, the infant must receive all health care services, including audiology services, through that plan. The plan is identified on the mother's Medicaid Identification Card. Contact the HMO for questions about coverage of service, billing and reimbursement.

Fee-for-Service Clients: Urban Hospital

When the mother is not enrolled in any type of managed care plan, services in a hospital in Salt Lake, Utah, Davis or Weber Counties are covered under the diagnosis-related group (DRG) payment received by the hospital. The DRG payment includes the hearing screen for the infant. The hospitals should reimburse the audiologist. The hearing screen is **not** separately billable.

Fee-for-Service Clients: Rural Hospital

When the mother is not enrolled in any type of managed care plan, and services are in a hospital other than Salt Lake, Utah, Davis or Weber Counties, inpatient reimbursement is billed as fee-for-service. Accordingly, an audiologist may bill Medicaid for the service with procedure code V5008, hearing screening (infant). Medicaid will pay the audiologist's claim separately because hospital services are not covered by a diagnosis-related group payment (DRG).

For questions concerning payment of fee-for-service claims, contact Medicaid Information. **G**

99 - 10 Hepatitis B Immune Globulin (HBIG) for High-Risk Infants

Effective November 1, 1998, local hospitals were asked to obtain and use their own supply of Hepatitis B Immune Globulin (HBIG) for high-risk infants born to hepatitis B surface antigen-positive mothers. In accordance with the recommendation by the U.S. Public Health Service's Advisory Committee on Immunization Practices (ACIP), infants born to identified hepatitis B surface antigen (HBsAg)-positive mothers should receive HBIG and their first dose of hepatitis B vaccine prior to discharge from the hospital. Because of ACIP's recommendation, Medicaid will pay for HBIG for Medicaid-eligible high-risk infants.

Hospitals are obligated to provide HBIG for administration to high-risk infants because it is recommended and considered to be the standard of care. For infants born to Medicaid eligible mothers in urban hospitals, newborns are covered under the DRG, and the hospital should not bill for administering the drug. The pharmacy may bill for HBIG dispensed using the NDC number.

In the past, the State Immunization Programs, Perinatal Hepatitis B Project, purchased and supplied HBIG for these high-risk infants. The Project sent HBIG to local health department case managers who, in turn, distributed it to hospitals where HBsAg-positive pregnant women deliver. Unfortunately, the Project's supply of HBIG expired October 1, and staff have been unable to purchase additional product. There are only two manufacturers of HBIG in the United States: Abbott/NABI and Bayer. Abbott/NABI has no product available. Bayer released only limited supplies. Therefore, as of November 1, 1998, local health department perinatal hepatitis B case managers are advising hospitals that, until further notice, they need to obtain and use their own supply of HBIG for high-risk infants. **G**

99 - 11 Coverage and Recommended Guidelines for Synagis®

Medicaid covers the new drug Synagis® (palivazumab) when administered by a physician, an osteopath or a licensed nurse practitioner to a child age 24 months or younger who is at high risk of hospitalization, morbidity, or mortality due to respiratory syncytial virus (RSV). Criteria for coverage, as described in this bulletin, have been added to the Drug Criteria and Limits list attached. If the patient is enrolled in a managed care plan, Synagis is covered, but the provider must consult with the patient's plan for coverage criteria and reimbursement.

Because of the high cost of this product, Medicaid does not cover Synagis for clients over age 24 months and does not cover children age 24 months or younger who are not at high risk due to RSV. Medicaid covers approximately one-third of all infants born in Utah each year, which is approximately 13,333 newborns. Two-thirds of all newborns will have had an respiratory syncytial virus (RSV) infection by age one. All children will have had at least one RSV infection by age three. Therefore, Medicaid is restricting coverage to high-risk children.

Guidelines for High-Risk Children

Medicaid follows the guidelines recommended by the DUR Board for use of Synagis. There are five conditions for coverage as listed below:

1. The patient does not have active RSV (respiratory syncytial virus) infection.
2. The patient is high risk for hospitalization, morbidity, or mortality due to respiratory syncytial virus (RSV).
3. The patient has life expectancy of over six months.
4. The patient is not on a mechanical ventilator full time.
5. The patient meets the conditions of either (a) or (b) below:
   - (a) The patient is six months of age or younger and had ≤ 32 weeks gestation; **OR**
   - (b) The patient is ≤ 24 months of age, normal gestation and meets one of the following criteria:
     - (1) The patient has had a clinical diagnosis of BPD (Broncho pulmonary dysplasia) requiring ongoing medical treatment within the last six months;
     - (2) The patient has been on oxygen withing the last six months; or
     - (3) The patient has had in the last six months steroids, bronchodilators, or diuretics.

Dosage and Limitations

The recommended dosage is 15mg/kg of body weight. Doses are limited to five per year administered once a month for five consecutive months, typically November through March, or the end of the RSV season, which ever comes first.

Billing for Synagis

Until a unique J code is assigned to Synagis® (palivazumab), use code J3490 to bill for this new drugs. On page 1 of Medicaid's list of Injectable Medications, the instructions state that J3490 may be used for new drugs which have not been assigned a unique J code. If you submit the claim on paper, follow the instructions to identify the name of the drug, the strength and quantity on the claim form. If you bill the claim for J3490 electronically, a staff person will contact you to determine specifically the drug used. We will advise you as soon as a J code is assigned.

Reimbursement for Synagis®

Medicaid will reimburse Synagis®, manufactured by MedImmune, Inc., at the direct manufacturer purchase price plus 10 percent (direct price + 10%). As of December 1998, the direct manufacturer purchase price is $901.17. The direct price + 10% is $991.29.

The provider may bill for services as directed in the Physician Services Provider Manual, Section 2, Chapter 2, COVERED SERVICES, item 23, which states, "An injection code which covers the cost of the syringe, needle and administration of the medication may be used with the "J" Code when medication administration is the only reason for an office call. Note: An office visit, "J" Code, and an administration code cannot be used all for the same date of service. Only two of the three codes can be used at any one time or at any one visit."

Preparation of Synagis®

Follow directions on package insert carefully for mixing Synagis.

- C **DO NOT SHAKE VIAL.**
- C **DO NOT FLUSH THE DILUENT DIRECTLY ONTO THE POWDER.** Synagis foams excessively when shaken and the foam may not settle until after the reconstituted drug's shelf life of 6 hours has lapsed. Let the diluent slowly run down the side of the vial to the powder.
- C Gently swirl the contents or roll the vial to mix the diluent and powder. **G**

99 - 12 Medical Transportation Services: Medicaid Provider Manual Updated

Transportation providers will find attached Section 2 for the Utah Medicaid Provider Manual for Transportation Services. The old policy for transportation services, dated June 1995, and subsequent Medicaid bulletins on transportation services are now obsolete. Highlights of the new manual are in this bulletin. Substantive policy changes and clarifications are marked with a vertical line in the margin of pages in Section 2. Instructions on updating the provider manual are on page 2 of this bulletin.

Please direct questions, including requests for manuals, to Medicaid Information. Refer to the box at the bottom of the page or to the black box on page two "Requesting a Medicaid publication or form?".

Changes to the Transportation Services Manual

The updated manual describes covered services, limitations, non-covered services, monitoring, billing and codes. Major changes are as follows:

6. Chapter 1, *General Policy*, now includes the following:
   - < Credentials required
   - < Verifying Medicaid eligibility
   - < Transportation to mental health services
   - < Monitoring, record keeping and report of abuse

2. All criteria which pertain to any provider of transportation service have been consolidated into Chapter 2, *Covered Transportation Services*. Criteria include the following:
   - < Transportation to Medicaid-covered service
   - < Transportation to nearest provider
   - < Cost-effective transportation
   - < Inpatient hospital or resident of nursing facility
   - < Patient in need of care en route
   - < Prior authorization for medical transportation required BEFORE service provided
   - < Prior authorization for non-emergency transportation for after-hours urgent medical care required within THREE working days.

3. Other criteria for bus, taxi, or van transportation are now placed into Chapter 3, *SPECIFIC CRITERIA FOR TYPES OF NON-EMERGENCY TRANSPORTATION*. Taxi providers, please note two policy clarifications:
   A. A taxi may not be used to pick up prescriptions at a pharmacy unless in route from a medical appointment. New prescriptions should be filled directly after the visit to the prescribing medical practitioner as a segment of that trip. Exceptions to this limitation require prior authorization. Additionally, Medicaid does not cover transportation to obtain prescription refills at a pharmacy which offers delivery service.
   B. Taxi service is not available to Medicaid recipients in cases of inclement weather, appointment scheduling conflicts, distance from a provider, or lack of funds to take the bus.

4. Other criteria for ambulance transportation are now placed into Chapter 4, *AMBULANCE TRANSPORTATION*.

5. Chapter 5 covers out-of-state transportation.

6. Chapter 6 gives examples of non-covered services.

7. Chapter 7 lists billing codes and descriptors. Current, existing codes added to the manual are:
   - < A0140, air travel
   - < Specialized van service codes:
     - Y1170 Special negotiated base rate for vans
     - Y1172 Special negotiated mileage rate for vans
     - Y1171 Attendant, special negotiated rate for vans

Instructions for Updating the Transportation Manual

Follow three steps to update the manual using the pages attached to this bulletin and the old Medical Transportation Manual.

Î KEEP the following:
- C Section 1, General Information
- C General Attachments for all manuals

Ï DISCARD "Chapter 40 - Medical Transportation", pages 1 through 8.

Ð ADD Section 2, the General Medical Form and instructions. G

99 - 13 Drug Limitations: APAP (acetaminophen); Carisoprodol; Low Molecular Weight Heparins

The effective dates in Bulletin 98 - 88, *Drug Limitations on APAP (acetaminophen) and Carisoprodol*, published in October 1998, have been revised. That bulletin stated the effective date for limits on select schedule III analgesics was November 1, 1998, and the effective date for the limit on Carisoprodol was October 1, 1998. **All effective dates are January 1, 1999.** Bulletin 98 - 88 is now obsolete.

For your reference, the corrected information appears below.

APAP (acetaminophen)

The Drug Utilization Review (DUR) Board has set limits on select schedule II & III analgesics. Effective January 1, 1999, Propoxyphene/APAP, hydrocodone/APAP, Codeine/APAP and Oxycodone/APAP in any combinations are restricted to a limit of 180 tablets in any 30-day period. Narcotic analgesics in combination with ASA or ibuprofen are not included in this restriction.

Carisoprodol

Effective January 1, 1999, Carisoprodol is limited to 120 (1 tablet q6h dosing) tablets in any 30-day period.

Low Molecular Weight Heparins

Effective July 17, 1998, the limit on low molecular weight heparins (LMWH) increased to 20 units in any 30-day period.

The drugs cited in this bulletin and others limited to a cumulative quantity in any 30-day period are included on the Drug Criteria and Limits list included with this bulletin. For information about this list, please refer to Bulletin 99 - 14, *Drug Criteria List Revised.* **G**

99 - 14 Drug Criteria List Revised

Physicians, osteopaths, licensed nurse practitioners and pharmacists will find attached pages 1 through 2B and 13 - 14 of the Drug Criteria list. This list now includes all drugs limited to a cumulative quantity in any 30-day period. The drugs on this list do not qualify for 'early refills'.

The limits have been approved by the Drug Utilization Review (DUR) Board. Physicians and other prescribers who feel that a patient has specific needs which exceed the limits may appeal to the DUR Board. All medications remain subject to all other requirements of Pharmacy Program, as described in the Utah Medicaid Provider Manual for Pharmacy Services.

References: Utah Medicaid Provider Manual for Pharmacy Services, Section 2, Chapter 4 - 7, *Early Refills*, and Chapter 4 - 9, *Limits on Certain Drugs*.

Synagis® Added to List

Criteria for the new drug Synagis®, as described in bulletin 99 - 11, Coverage and Recommended Guidelines for Synagis®, have been added to the Drug Criteria and Limits list.

Updating the Drug Criteria List

Remove existing pages 1 - 2 from the Drug Criteria list. Insert the attached pages 1 through 2 B. Hereafter, this list will be referred to as the Drug Criteria and Limits list. **G**

99 - 15 Pharmacy Manual Revised: Limits on Certain Drugs

Section 2 of the Utah Medicaid Provider Manual for Pharmacy Services has been revised to clarify the policy concerning drugs with limitations set by the Drug Utilization Review (DUR) Board. The corrections are listed below. For complete information, refer to the corrected page attached. Instructions for inserting these pages into the pharmacy manual are at the end of this bulletin.

Chapter 4 - 7, *Early Refills*

Item A, Early Refills Not Authorized, is revised to add a sub-item 5.

8. Medicaid will not authorize an early refill for drugs limited by quantity for any 30-day period. Refer to Chapter 4 - 9, Limits on Certain Drugs, and to the Drug Criteria and Limits List included with this manual.

Chapter 4 - 9, Limits on Certain Drugs

This chapter is revised to move the list of drugs with limitations to the Drug Criteria and Limits list. Policy is clarified as follows:

> Drugs identified on the Drug Criteria and Limits List included with this manual are limited by quantity for any 30-day period. These drugs have a cumulative limit and do not qualify for early refills under Chapter 4 - 7, *Early Refills*. The limits are those approved by the Drug Utilization Review (DUR) Board. Physicians and other prescribers who feel that a patient has specific needs which exceed the limits may appeal to the DUR Board. All medications remain subject to all other requirements of the Pharmacy Program, as described in the Utah Medicaid Provider Manual for Pharmacy Services.

Updating the Pharmacy Manual

Remove pages 20 - 21 from Section 2 of the Pharmacy Manual with Chapters 4 - 7 through 4 - 9. Insert the attachment with pages 20 - 21 dated January 1999. **G**

99 - 16 Dosage Limit on 'Triptans' for Migraine Headaches

Effective January 1, 1999, the Drug Utilization Review (DUR) Board set a limit for any combination of 'triptans' for migraine headaches to 18 doses (units) in any 30-day period. A dose includes tablets, syringes, and nasal amps of Amerge®, Imitrex®, Maxalt®, Zomig® or other triptans. **G**

99 - 17 Preven - "morning after pill"

Effective September 23, 1998, Medicaid began coverage of the drug Preven (NDC 63955001001). Following the recommendation of the Drug Utilization Review (DUR)Board, the cumulative limit is two kits in any 30-day period.

The drug is limited because it is more cost effective to use the traditional oral contraceptives. Generic birth control paks cost as little as $11.00 for a 28- day supply (Genora 1/35 = $10.72). Preven costs $19.94/kit. **G**

99 - 18 Medical Supplies Must be Year 2000 Compliant

Effective January 1, 1999, all medical supplies provided to Medicaid recipients (either as a rental or a purchase) must be Year 2000 compliant. This means that supplies, such as equipment with any functions which are date dependent, must be able to operate without interruption due to the date change on January 1, 2000.

Medicaid now requires written prior authorization for any medical equipment with a date function which is not Year 2000 (Y2K) compliant. As always, authorization must be obtained BEFORE the equipment is provided to a Medicaid recipient. Failure to obtain prior authorization for supplies which are not Y2K compliant will result in payment recovery. **G**

99 - 19 Pharmacists: Federal Upper Limits

The federal Health Care Financing Administration (HCFA), through the Federal Upper Limit Bureau, provides to the State Medicaid agency a biannual list which contains the mandated generic, multi-source level of reimbursement for the identified drugs. Revisions are generally made January 1 and July 1 each year.

First Data Bank, under contract to Utah Medicaid, maintains these pricing regulations on the Utah Master Reference File. Generic substitution may only be made with products with an A rating identified in the Approved Drug Products (orange) Book published by the U. S. Department of Health and Human Services. The Federal Upper Limit information is available through the Medicaid Point of Sale system and on the Internet at the following URL:

http://www.hcfa.gov/medicaid/drug10.htm

The information about the Internet location of the FUL list has been added to the on-line Utah Medicaid Provider Manual for Pharmacy Services, Section 2, Chapter 1 - 2, *Federal Upper Limit List.* You can locate the on-line manual using a link at the following URL:

http://hlunix.ex.state.ut.us/medicaid/html/section_2.htm

A paper copy of the FUL list may be obtained by contacting Medicaid Information. If you have a question, contact either:

Raedell Ashley	538-6495
Duane Parke	538-6452

To call toll-free, call Medicaid Information. Ask for Raedell Ashley at extension 86495 or Duane Parke at extension 86452. **G**

99 - 20 CHIP and Vaccines for Children

Children receiving health coverage through the Children's Health Insurance Program (CHIP) do not qualify for Vaccines for Children (VFC) products. Immunizations for these children are covered by CHIP. As a reminder, children who fit in any of the following VFC categories may receive VFC products:

1. Children enrolled in Medicaid
   NOTE: Medicaid pays only the administration fee for these immunizations. Medicaid does not pay for product.
2. Children with no health insurance. (Uninsured)
3. American Indians and Alaskan Natives.
4. Children with health insurance which does not cover immunizations. (Underinsured.)
   NOTE: At this time, these children must receive their VFC immunizations at a Federally Qualified Health Center.

We are following discussions on the federal level about potential changes to the VFC program and will communicate any changes to you as soon as possible. Finally, we want to thank you for your efforts to make sure children in Utah receive adequate and appropriate immunizations.

For more information on VFC, or to become a VFC provider, please contact Kathy Hoenig of the Utah Department of Health Immunization Program: 538-9450 or email to khoenig@doh.state.ut.us. **G**

99 - 21 CHEC Immunization Schedule for 1998

Physicians, osteopaths and licensed nurse practitioners will find attached pages 14 - 15 of the Utah Medicaid Provider Manual for Child Health Evaluation and Care Program (CHEC) services. Appendix B, page 16, is the Immunization Schedule for 1998. The 1998 schedule replaces the 1997 schedule. The schedule for 1999 is not yet available. Please remove the old pages 14 -15 with Appendix B dated April 1997 and replace it with the page attached. **G**

99 - 22 Domestic Violence: Its Impact on Health Care Professionals

A 24-year-old pregnant female complains to her obstetrician of pelvic pain, cramping, backache and vaginal bleeding. She subsequently has a spontaneous abortion.

A 46-year-old female, is seen by a gasteoterologist for chronic abdominal pain and diarrhea of six-month's duration.

A 60–year-old female suffering from a possible drug overdose of Valium is taken to an emergency department.

These women present in diverse medical settings with a range of complaints, but with similar histories. All are victims of violence by their intimate partners. It is also likely that the violence causing their injuries will not be identified.

Many women seek medical attention for injuries or illness related to violence. The American Medical Association estimates that nearly twenty-five percent of women in the United States will be abused by a partner sometime during their lives and that up to thirty-five percent of women seeking care for any reason in emergency departments are victims. A recent Dan Jones study found that more than 40,000 Utah women are physically abused by an intimate partner each year and 194,000 are subjected to emotional abuse. Battered women also see health care professionals for non-emergent care, primary care, psychiatric services and prenatal care.

Abuse often begins or increases during pregnancy. The abuser is more likely to direct blows at a woman's breasts and abdomen which put the mother and the fetus at risk. Dangers to the fetus may include miscarriage, low birth weight, and direct injury.

More than 160,000 Utah children live in homes where their parents hurt each other. Half of the children will be victims of physical abuse, and all will suffer from the trauma of witnessing or hearing violence in their homes. Alcohol and drug abuse, gang violence, delinquent behavior, and teen pregnancy are often the fruit of the tree rooted in domestic violence.

Intervention through Health Care

Appropriate health care interventions can help interrupt the progression of violence and prevent the development of other complex problems. For example, fear of harm to an unborn baby often will motivate a woman to change an abusive relationship.

The first step toward creating an appropriate intervention strategy is to ensure all health care providers have an accurate understanding of the definition, nature and extent of intimate partner violence. Domestic violence is a pattern of coercive behavior that can include physical, sexual, economic, and/or emotional abuse of one family member to another. Perpetrators of domestic violence try to establish and maintain power and control over their partners. Inappropriate control includes a wide range of damaging behaviors such as depriving a woman of money, food, sleep, clothing, or transportation; isolating her from her family and friends; and controlling reproductive choices by forbidding sterilization or sabotaging birth control. Domestic violence may affect people in every racial, ethnic, socioeconomic and age group who live together or who have an intimate relationship. The violence often escalates in severity and frequency over time.

Lack of education about domestic violence, coupled with misconceptions about the dynamics of abuse, leads to a highly inadequate health care delivery system for battered women. The traditional medical response to an abused woman has been to treat only the presenting medical problem without addressing the violence that may be the cause. As a result, pregnancy complications, miscarriages, drug and/or alcohol addictions and sexually transmitted diseases, including HIV, may be the sole focus of treatment, instead of a symptom of abuse.

Mandatory Reporting Law

Health care providers also need to be aware that the Utah has a mandatory reporting law on the issue of domestic violence. Health care professionals treating or caring for an injury due to domestic violence must report the incident to their local law enforcement. Therefore, we encourage all health care facilities to develop a domestic violence protocol and all health care providers to receive training to

ensure appropriate responses to patients who may be in an abusive relationship.

Training Offered to Health Care Professionals

The Utah Department of Health provides training for health care professionals on how to assess, treat and refer victims of partner abuse. This training was developed in concert with the Utah Domestic Violence Advisory Council and has been adopted by the Utah Academy of Family Practitioners and Utah Medical Association.

Guidelines for Assessment, Treatment and Referral of Victims of Partner Abuse Available

Providers may also request a manual, "Guidelines for Assessment, Treatment and Referral of Victims of Partner Abuse." The manual contains information on the following:

- C laws
- C definitions
- C myths and facts
- C questioning patients regarding possibility of abuse
- C appropriate documentation
- C assessing safety of a victim
- C a guide to community resources
- C a sample protocol (policy and procedures) with a flowchart.

To Request More Information, Training or Manual

For more information, to schedule a training, or to request a manual contact Allison Librett at the Utah Department of Health:

Salt Lake area: 538-6268

Toll-free: 1-800-894-7651

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99 - 23 Medicaid Authorization: Prior and Retroactive

The requirement to obtain prior authorization and limited exceptions are described in the Utah Medicaid Provider Manual, Section 1, Chapter 9, *PRIOR AUTHORIZATION PROCESS*. The following two pages, 15 -16 and 16A - 16B, replace Chapter 9 in its entirety. Changes include:

- , clarifying the introduction to Chapter 9;
- , clarifying prior authorization procedures described in Chapter 9 - 4;
- , revision of exceptions under Chapter 9 - 7, *Retroactive Authorization*.

Instructions for Correcting Section 1, Chapter 9

Please use the following two pages to replace Section 1, Chapter 9, of your Medicaid Provider Manual. We intend to reissue Section 1 in its entirety in July 1999 to incorporate this bulletin and other corrections. In the meantime, please update Section 1 as follows:

1. On the existing page 15, cross out Chapters 9 through 9 - 2.
2. Remove Section 1 pages 16 -17 dated April 1996.
3. Then cross out the remainder of Chapter 9 - 7 and Chapter 9 - 8 which appear on page 18 dated April 1996.

The on-line version of Section 1 accessible on the Internet at **http://hlunix.ex.state.ut.us/medicaid/html/chapter_9.htm** has been corrected according to these instructions.

On the corrected pages which follow, significant changes are marked with a vertical line in the margin. **G**

9 PRIOR AUTHORIZATION

Prior authorization is an approval given by the Medicaid agency, prior to services being rendered, for procedure codes identified in Section 2 as requiring prior authorization. Approval must be obtained precedent to service being provided. Prior authorization confirms that services requested are needed, that they conform to commonly accepted medical standards, and that all less costly or more conservative alternative treatments have been considered. Prior authorization does not guarantee reimbursement. All other Medicaid requirements must be met in order for a provider to receive reimbursement.

A. Prior authorization (PA) requirements apply ONLY for services which may be covered directly by Medicaid. These include services for a patient assigned to a Primary Care Provider or services not included in a contract with a managed care plan.

B. The PA requirements and process do **not** apply for services covered by a managed care plan when the Medicaid patient is enrolled in that managed care plan. Each plan specifies which services it covers, which require authorization, and the conditions for authorization. Because information as to what plan the client must use is available to providers, the provider must follow the plan's procedures for authorization in order to receive reimbursement.

   Medicaid cannot process requests for prior authorization for services included in a contract with a managed care plan. Providers requesting services for a client enrolled in a managed care plan will be referred to that plan. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client's plan, Medicaid cannot pay for the service. If the provider fails to follow the plan's procedures for authorization, the managed care plan may also refuse to pay for the service.

C. If a provider is required to obtain prior authorization, fails to do so, provides service anyway, and then bills Medicaid, Medicaid must deny the claim. Because it was the provider's responsibility to obtain authorization, the provider is prohibited from subsequently billing the patient for the unpaid service. Reference: Utah Medicaid Provider Manual, Section 1, Chapter 6, *Provider Enrollment and Compliance*.

D. There are specific, limited exceptions to the requirement that approval must be obtained BEFORE service being provided. The exceptions are explained in and limited by Chapter 9 - 7, *Retroactive Authorization*.

9 - 1 Unspecified Services and Procedures

Unspecified services or procedures covered by Medicaid do not require prior authorization. These codes typically are five numbers ending ". . .99". Do **not** use unspecified service or procedure codes to provide services which are not a Medicaid benefit. Submit documentation for these codes with the claim form for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure.

9 - 2 Non-Covered Procedures

Generally, Medicaid does not reimburse non-covered procedures. However, exceptions may be considered through the prior authorization process in the circumstances listed below and when no code that is a Medicaid benefit accurately describes the service to be provided:

1. The patient is a child under 21 years of age. Because of the patient's age, the Child Health Evaluation and Care Program (CHEC) may pay for services which are medically necessary but not typically covered by Medicaid. The CHEC program is based on a preventive health philosophy of discovering and treating health problems before they become disabling and therefore more costly to treat in terms of both human and financial resources. Please refer to the Utah Medicaid Provider Manual for CHEC, Section 2, for additional information. For your convenience, the PA requirements for CHEC services are listed in the subsequent Chapter 9 - 3, *Criteria*.

2. Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.

3. Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).

4. When performing the procedure is more cost effective for the Medicaid Program than other alternatives.

9 - 3 Criteria

The criteria used by Medicaid staff to review a prior authorization request are described in Section 2 or listed with each procedure code requiring PA.

When a service is not ordinarily covered by Medicaid, but it is for a child under 21 years of age, Medicaid may authorize the service under the Child Health Evaluation and Care Program (CHEC). For complete information, please refer to the Utah Medicaid Provider Manual for CHEC Services. Prior authorization requests for CHEC services must be in writing and include the information listed below:

1. The estimated cost for the service or item;

2. A photocopy of any durable medical equipment item(s) requested;

3. A current comprehensive evaluation of the child's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested;

4. A letter from the physician describing medical necessity and including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be patient specific, indicate the reasons the physician is recommending the service or equipment, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

The physician making the request, the therapist and the provider should communicate directly and work as a team to evaluate the most appropriate services for the child.

9 - 4 Prior Authorization Procedures

Prior authorization (PA) applies to all services which require PA and which are either:

(1) Not covered by a capitated managed care plan, or

(2) In one of the following programs: Psychology, Personal Care Services, Targeted Case Management Services, and Home and Community-Based Waiver Services. Providers of these services should follow the prior authorization process in the applicable provider manual.

A. When prior authorization is required for a health care service, the provider must obtain approval from Medicaid BEFORE service is rendered to the patient. Medicaid can pay for services only if ALL conditions of coverage have been met, including but not limited to, the requirement for prior authorization.

B. A provider must complete a Request for Prior Authorization form and submit it with any required documentation to the Medicaid agency as indicated. A copy of the Request for Prior Authorization form and instructions are included with this manual in the General Attachments section.

1. Any exception to the requirement for written prior authorization is noted in Section 2 of this manual for specific provider types and services. A code which requires PA indicates whether the request may be made by telephone or must be in writing. For example, a *telephone* request for prior authorization may be permitted for certain services.
2. Generally, the provider sends a request for Prior Authorization to the Utilization Management Unit in the Division of Health Care Financing. Any exception is noted in Section 2 of this manual.

C. The Medicaid agency reviews the request to determine if the service is covered by Medicaid and if it meets the criteria for medical necessity, based on information given by the provider.

1. A service may be covered when it is included in either of these groups:
   a. Within one of the 21 types of service covered by the Utah State Plan for adults, or
   b. Within one of the 25 types of service listed in 42 USC 1396d(a) for children under the age of 21.
2. A service is considered medically necessary when it meets the conditions of Chapter 7, MEDICAL STANDARDS - MEDICAL NECESSITY.

D. Medicaid sends a written notice to the provider, and a copy to the patient, advising of the request for authorization and the decision. Federal regulations (42 CFR §431.206) require Medicaid to "give notice to the patient" when any action "may affect his claim."

1. When the service is covered, but there is not enough information to determine medical necessity, a letter is sent to the provider, and a copy to the patient, requesting specific additional information. The provider must furnish the necessary documentation or information with the cooperation of the Medicaid patient.

   a. The letter states intent to deny the service because of insufficient information. It explains additional information needed. **Twenty-one days** are allowed for receipt of the information requested.

   b. If the requested information is not received within 21 days, the request is denied.

   c. If the request is denied solely because of insufficient documentation, and either the patient requests a hearing or the documentation is sent in, the Program Manager in the Division of Health Care Financing responsible for hearings can either process a new request for prior authorization **or** proceed with a hearing. The request cannot proceed simultaneously through both a hearing and the prior authorization process.

2. When Medicaid denies authorization, the letter of denial includes the following information:

   a. The action the State intends to take;

   b. The reasons for the action, including findings of fact;

   c. Statement of the laws and criteria supporting the action;

   d. The patient's right to a hearing;

   e. The process to request a hearing;

   f. The patient's right to be represented by an attorney or other person;

   g. The circumstances, if any, under which the service is continued pending the outcome of the hearing.

   Attached to the letter are a copy of the laws and criteria supporting the decision and a form and instructions for requesting a hearing.

   The denial letter **does not** ask for new information. Once a request is denied, the next opportunity to discuss the decision and present additional information for consideration is a prehearing conference. The only exception is explained in item D 1 c above which begins “If the request is denied solely because of insufficient documentation.”

E. When a patient submits a request for a hearing, Medicaid follows the policy and procedure under Utah Administrative Code, Section R410.14.

9 - 5 Written Prior Authorization

Send written requests to:

MEDICAID PRIOR AUTHORIZATION UNIT
P. O. BOX 143103
SALT LAKE CITY UT 84114-3103

Prior authorization requests may also be faxed to **(1-801) 538-6382**, attention "Prior Authorizations"

9 - 6 Telephone Prior Authorization

When policy permits a request for authorization to be made by telephone, call Medicaid Information:
In the Salt Lake City area, call **538-6155**
Call toll-free in Utah, Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado **1-800-662-9651**
From all other areas **1-801-538-6155**

Follow the telephone menu prompts. Press **3** for providers. Press **3** again for prior authorizations. Then press the menu option that corresponds to the service for which prior authorization is being requested.

9 - 7 Retroactive Authorization

Retroactive authorization is approval given after a service has been provided. Retroactive authorization may be considered ONLY in the circumstances listed in this chapter. The provider must complete a Request or Prior Authorization form and include documentation for the reason service was provided before Medicaid gave authorization.

A. Retroactive Medicaid Eligibility

When a client becomes eligible for Medicaid after receiving services which would have required prior authorization, Medicaid may consider a prepayment review, rather than denying reimbursement solely because prior authorization was not obtained. The provider should explain this circumstance on the Request for Prior Authorization form.

B. Medical Supplies Provided in a Medical Emergency

Certain medical supplies and equipment that require prior authorization may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, and an item on the list below is provided, Medicaid may consider the request for retroactive authorization and payment.

- Enteral and parenteral therapy equipment
- Enteral or parenteral nutrients
- Hospital bed and related equipment
- Oxygen and related respiratory equipment
- Gaseous oxygen or liquid oxygen only when supplied to a private client who subsequently becomes Medicaid eligible
- Humidifier/nebulizer

Only the supplies and equipment in the list above may be considered for retroactive authorization. It is the responsibility of the medical supplier to substantiate the emergency and provide the necessary documentation to support a prepayment review. Providers must obtain prior authorization for all other services, supplies, and equipment, even if the client's circumstances appear to qualify as an 'emergency."

C. Surgical Emergency

Surgical procedures that require prior authorization may be performed in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment. To qualify, the procedure must have been performed in a life-threatening or justifiable medical emergency. An example is the procedure to terminate an ectopic pregnancy.

It is the responsibility of the surgeon to substantiate the emergency and provide all necessary documentation to support a prepayment review of the services for all providers concerned. Documentation from the medical record to support the emergent nature of the procedure includes the following:

1. Patient history and physical
2. Consent form, if applicable (hysterectomy, sterilization or abortion), completed according to instructions. Refer to Section 2 of the Medicaid Manual for Physician Services.
3. Operative report
4. Pathology report
5. Discharge summary

D. Medicaid is responsible for the delay in authorization.

9 - 8 Ancillary Services

When the service requires prior authorization (PA) and a PA number is obtained from Medicaid, please give a copy of the patient's Medicaid Identification Card or, at minimum, the Medicaid Identification number **and the PA number** to all providers rendering ancillary services to the patient. This will assist the other providers who may be required to submit the PA number when billing Medicaid. Other providers include lab, x-ray, and anesthesiology services.